SUICIDE

& Other Psychiatric Emergencies

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Objectives

- Understand the epidemiology of suicide in the Navy and the general population
- Learn the Navy policies involved in suicide prevention
- Develop skills to perform a clinical assessment and recommend treatment

SUICIDAL BEHAVIOR IS A LIFE-THREATENING MEDICAL EMERGENCY

Epidemiology of Suicidal Behavior

IN THE MILITARY

- Third leading cause of death - 10% of all AD deaths
- Rate same as civilian: 10-12/100,000 annually
- An increase in the 15-24 age group (1/3 of AD Navy in this age group)- tripled in the past three decades

GENERAL POPULATION

- 9/1,000 people attempt suicide
- 1/10 endorse suicidal thoughts
- actual suicide rate has remained stable (increase in the younger group offset by a decrease in the middle-aged group)
- 30,000 deaths annually in the US (attempts about 10x)
- One suicide every 20 minutes

SUICIDES BY STATE

- Lowest rate for both sexes: NJ
- Highest for men: Nevada and New Mexico
- Highest for women: Nevada and Wyoming
- Women in Nevada killed themselves at a higher rate than men in NJ. . . . .
- The #1 suicide site in the world:

More Rates

- Men commit suicide 3x more than women
- Women attempt suicide 4x more than men
- Men use more violent methods
- Except for the 15-24 age group suicide increases with age: Men peak after 45; women after 55. For men >65: incidence of 40/100,000
- Elderly account for 25 % of suicides and only 10% of population

Rates Related to Race

- 3rd leading COD for 15-24 year old males (after accidents and homicide)
- Whites 2x higher rate than nonwhites - this is misleading in that the rates for the ghetto youth and young Native American and Alaskan Indians far exceed the national average.

Rates (cont.)

- Religion: suicide rates among Catholic populations are lower than the rates among Protestants and Jews (orthodoxy probably more important than religion)
- Marital Status: marriage with children greatly less
  - single, never-married have double the rate for married

Rates (cont.)

- Marital status (cont.)
  - Previously married much higher than single:
    - 24/100,000 among widowed
    - 40/100,000 among divorced
    - 69/100,000 among divorced males; 18 for women
- Occupation
  - higher the social status, higher the risk
  - a fall from social status increases the risk
  - work protects

Rates (cont.)

- Occupation (cont.)
  - Female physicians have highest rate: 41/100,000
  - Male physicians no increase
  - Psychiatrists>ophthalmologists>anesthe-siologists
  - Other: dentists, musicians, law enforcement officers, lawyers, and insurance agents

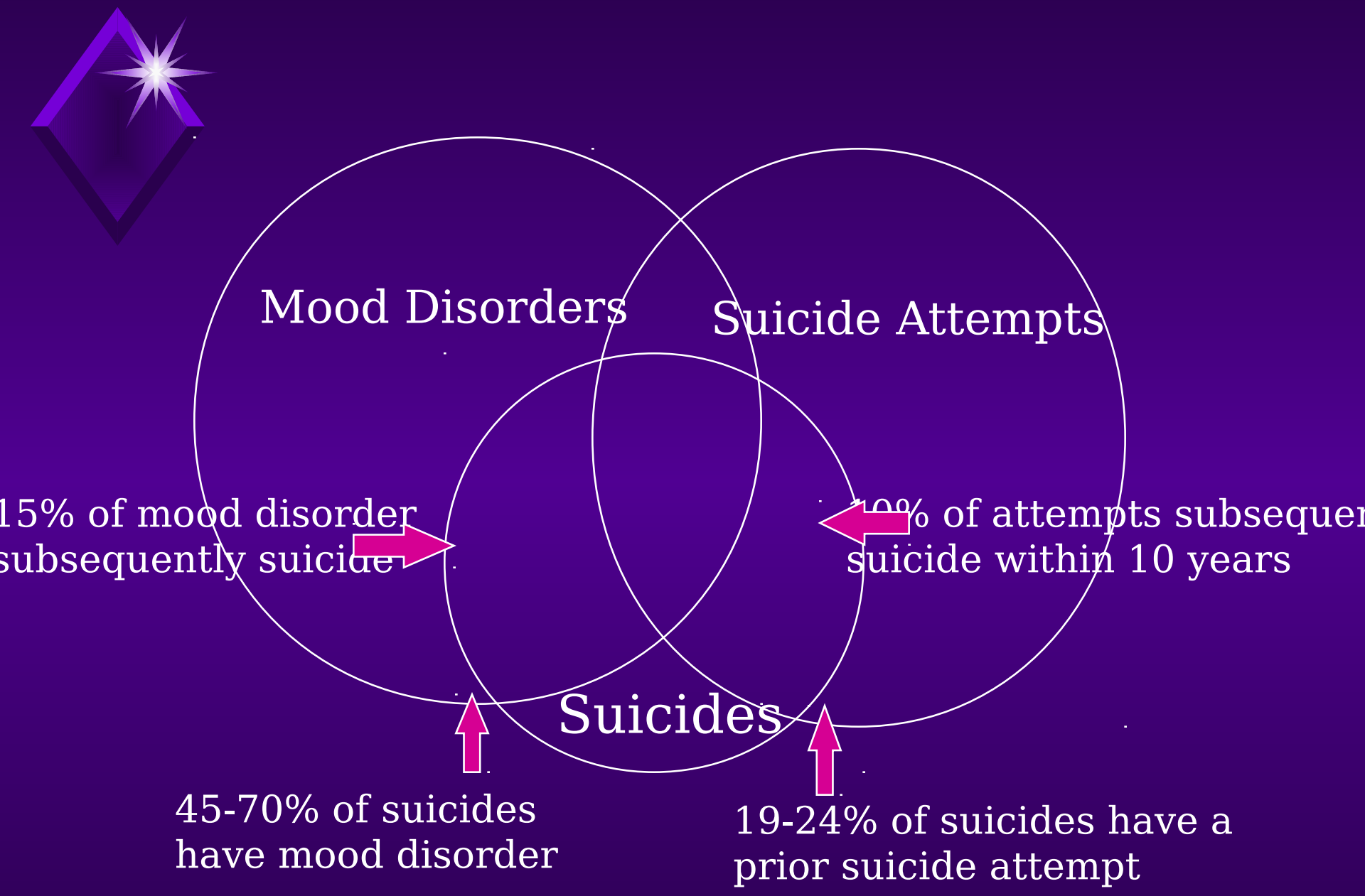
Rates (cont.)

- Physical health: strong relationship with suicide: postmortem studies show 25-75% of all suicide victims have some physical illness. Health is contributing factor in 11-51%
- Mental health:
  - almost 95% of all patients who commit or attempt suicide have a diagnosed mental disorder.

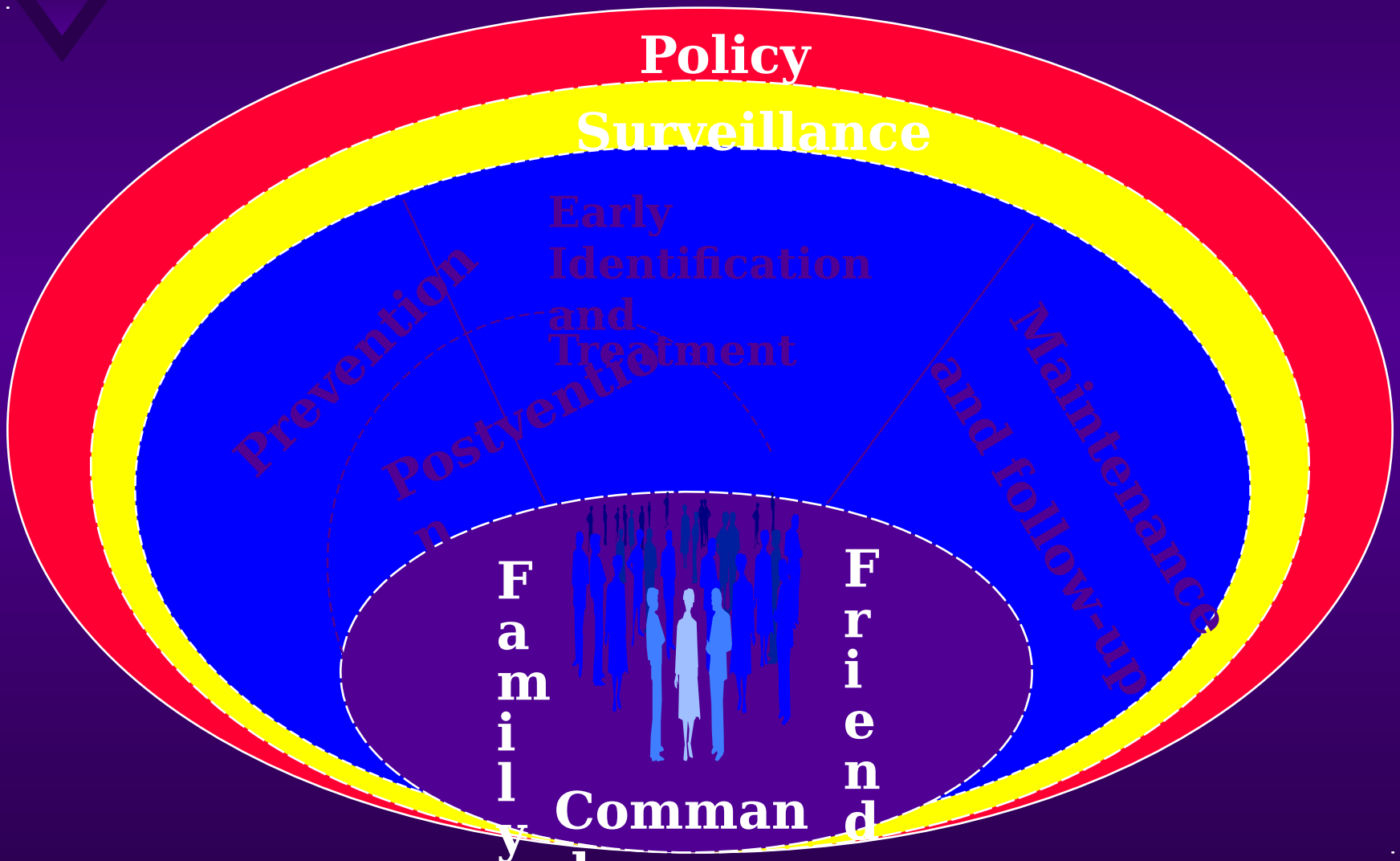
Rates (cont)

- Mental Health (cont.)
  - 80%depression, 10% psychotic disorders, dementia 5%
  - Risk in mood disorders:15%
  - Risk in alcoholism: 15% (270/100,000)
  - also significant in panic disorder and OC disorder

35-80% of all suicidal behavior is alcohol-related


Mood Disorders
Suicide Attempts
15% of mood disorder subsequently suicide
10% of attempts subsequen suicide within 10 years
Suicides
45-70% of suicides have mood disorder
19-24% of suicides have a prior suicide attempt

Navy Suicide Prevention Policy Overview


Policy
Surveillance
Prevention
Early Identification and Treatment
Postvention
Maintenance and follow-up
Family
Friends
Command

History

- 1775 - 1980’s
  - Patchwork
  - No centralized tracking
  - Medical/Legal/Moral debate
- 1980’s
  - Quality Of Life (QOL) programs
    - CO’s/OIC’s responsibility
    - Navy specific programs

Current Navy Policy Directly Addresses Suicide

- OPNAVINST 6100.2 25 Feb 92
  - Health Promotions Program
- MILPERSMAN 4210100
  - Casualty Reporting
- NAVMEDCOMINST 6520.1A 31 Mar 86
  - Evaluation and Disposition of

Risk

Current Navy Policy Directly Addresses Suicide

- SECNAVINST 6320.24 14 Dec 94
  - Mental Health Evaluations Of Members of the Armed Forces
- SECNAVNOTE 1700 28 Jul 94
  - Reinvestigation Requests

Current Navy Policy

Address Significant Risk Factors

- MILPERSMAN 3430150
  - Command response to UA
- US. Navy Regulations Art.1159
  - Personally owned weapons
- OPNAVINST 5354.4B 13 Sep 90
  - Alcohol Abuse Prevention

Current Navy Policy

Address Significant Risk Factors

- SECNAVINST 1754.1 12 Jun 84
  - DoN FSC Program
- OPNAVINST 6100.2 25 Feb 92
  - Health Promotions Program

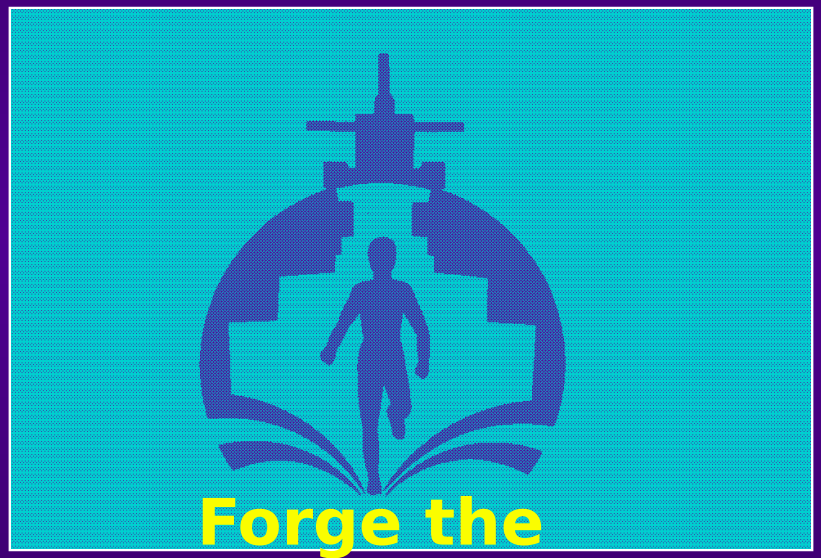
Current USMC Policy

Directly Address Suicide

- Marine Corps Health Promotions Program - Semper Fit 2000 MCO 6200.4 8 May 92
- Marine Corps Casualty Procedures Manual P-3040.4C

Policy Responsibility
OPNAVINST 6100.2

- Suicide Prevention an element of stress management
- PERS 6
  - Coordinates Policy



CO's / OIC's Responsibilities

OPNAVINST 6100.2

- Develop command program
- Ensure awareness of local suicide prevention programs
- Ensure availability of QOL programs

Develop command program

- Includes:
  - Suicide response SOP
  - Command-specific training

Ensure awareness of local suicide prevention programs

- Minimum requirement:
  - Orientation programs
  - GMT/GNT
- All other training is considered *“proactive”*

Ensure availability of QOL programs

Equal Opportunity	Morale Welfare & Recreation
Chaplain Programs (eg. Credo)	Health & Physical Readiness Programs
FSC Programs (eg. FMP, TAP)	Others (eg. PREVENT)

Suicide Activity Definitions

MILPERSMAN 4210100

- Part of *Casualty Reporting*
- Three types:
  - Suicide
  - Suicide attempt
  - Suicide gesture

Suicide Gesture

MILPERSMAN 4210100

- An intentional act, suggesting a cry for help, causing self-harm or intent to cause physical self harm *that would not cause death.*

Suicide Attempt
MILPERSMAN 4210100

- An intentional act, causing physical self-harm, where *death would have occurred without direct intervention.*

Suicide

MILPERSMAN 4210100 (CD ROM 1770)

- *Intentional*, self induced death.

Suicide Activity Definitions

MILPERSMAN 4210100

- For reporting purposes, the type of suicide activity is defined solely on the level of *lethality.*

Suicide Activity Reporting

MILPERSMAN 4210100

- *All* gestures, attempts and suicides *must be reported*.
- Report initiated by:
  - Parent command or
  - ISIC or
  - Local Naval Activity or
  - Medical Treatment Facility (MTF)

Suicide Activity Reporting

MILPERSMAN 4210100

- Only method of monitoring all types of injuries.
- *Not a personnel action* but a casualty/injury action.

Guidelines for Eval/Disposition

NAVMEDCOMINST 6520.1A

- ALL suicidal risk referrals must be done by mental health professionals
- Any suicidal act results in a period of observation
- Outpatient treatment (TPU/MEDHOLD) is appropriate

Mental Health Eval Protections

SECNAVINST 6320.24

- Prohibits use of mental health evaluation as reprisal
- Commands may still refer “emergencies” immediately

Reinvestigation Requests
SECNAVNOTE 1700

- Family may request reinvestigation via SECNAV.
- Reinvestigation by DoD.
- Important reason to *always* do a JAGMAN for suicides.

Command Response To UA

MILPERSMAN 3430150

- Inspect quarters
- Question cohorts
- Check hospitals, local law enforcement
- Check counseling (FSC, MTF, Chaplains)
- *This list is NOT all inclusive*

Possession of Weapons
U.S. Navy Regulations Art. 1159

- Personal weapons prohibited:

  "… on board any ship, aircraft, or any vehicle of the naval service or within any base or other place under naval jurisdiction."

- Exceptions set by "proper authority"

Alcohol Abuse Prevention

OPNAVINST 5350.4B

- Education of alcohol use risk
- Deglamorization
- Alternatives to use
- DAPA knows who has *ever* received treatment
- Right Spirit
  - ALNAV 11/96 (Mar 96)
  - NAVOP 8/96 (Mar 96)

DoN Family Services Center Programs
SECNAVINST 1754.1A

- Prevention of some problems
  - Family education programs
- Early intervention
  - Family advocacy
- Any program that improves individual coping skills can be part of suicide prevention

Health Promotions Instruction

OPNAVINST 6100.2

- Health contributes to better decisions
- Regular exercise, healthy diet contribute to stress management
- Responsible alcohol use reduces risk taking, promotes better decision making

Suicidal Behavior

Assessment and Management

Every suicide act is made with a degree of ambivalence and is a communication

Early Identification and Prevention

- Causes of Suicide
- Risk Factors
- Warning Signs
- Assessment of Risk
- Management

Causes of Suicide

- Loss of Close Relationship
- Loss of Career and/or Employment
- Loss of Financial Security
- Loss of Social Acceptance
- Loss of Health
- Loss of Self-Control
- Loss of Freedom (Disciplinary)

Feelings Associated with Loss (Bereavement)

- “Psychache” (Intolerable Life Pain)
- **Hopelessness******(high corroboration with risk)
- Helplessness
- Depression
- Worthlessness (Self-critical)
- Shame (Self-hate)
- Agitation/Anxiety/Panic

Risk Factors

- Relationship Problems
- Experience with Firearms
- Alcohol Abuse
- Unexplained Mood Changes or Depressed Mood
- Male

Risk Factors (cont.)

- Previous suicidal behavior
- h/o psychiatric d/o
- Personality disorder
- Unexpected physical disability
- FH:
  - unstable childhood/adolescence
  - abuse, neglect, rejection by parent
  - close relationship to someone who committed suicide

Warning Signs

- Suicidal Talk

  “I Wish I Were Dead”

  “If .....Happens, I’ll Kill Myself”

  “No One Cares About Me”

  “I Just Want All Of This To End”

Warning Signs

- Suicide Preparation
- Notes
- Giving Away Personal Possessions
- Final Arrangements

Warning Signs

- Preoccupation with Death
- Prior Suicide Gestures or Attempts
- Social Withdrawal
- Mood Changes

Technique of Assessment

- ***Non judgmental, objective, and empathetic***
- ***Preserve the dignity and avoid humiliating the patient***
- ***Encourage the patient to express concerns and plan***
- ***If made attempt - first stabilize***

Assessment (cont.)

- ***Assess aforementioned risk factors***
- ***If they have a plan:***
  - ***P - what is the proximity to help?***
  - ***A - what is the availability of means?***
  - ***L - what is the lethality of means?***
  - ***S - what is the specificity of the plan?***

Assessment (cont.)

- ***Assess information provided by others:***
  - available support
  - job stressors
  - impulsive behavior
  - safety of where pt will spend next 48 hours
  - attitudes of family, friends, and command
  - availability of chaplain, FSC, etc..

Management

- If suicidal risk is found - must admit to the nearest facility. No one who has made a suicide attempt should be sent home form a treatment facility without a psychiatric evaluation, and in most cases, inpatient evaluation (24-48h).
- If judged ***NOT*** a suicidal risk may be returned to the command with written documentation outlining the assessment, dx, and f/u recommendations - notify command by phone or through the escort.

Management

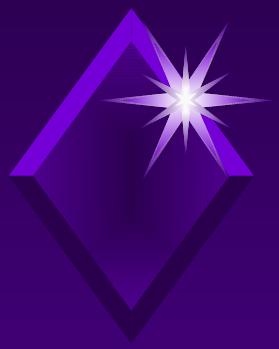
- ***If they are preconfinement and verbalize SIs and there is no AXIS I: may go to Brig***
  - ***"Close Observation"***
- ***THE SAFEST PLACE IS THE BRIG: (however, cannot send someone to the brig merely for safety purposes - must be under confinement or preconfinement orders. . .)***

Do's and Don'ts

- ***Clarify limitations but explore options and solutions***
- ***Avoid judgmental remarks and observe your body language***
- ***Refrain from making unrealistic reassurances, simple advice, or clichés***

Do's and Don'ts

- ***Don't leave the pt alone***
- ***Include family and friends if available***
- ***Inform the pt of your plans***
- ***Be available during the acute crisis even if hospitalized - visit - don't abandon***
- ***Therapeutic Alliance can't be underestimated (trust, empathy)***



Help the CO/OIC understand why a severely personality disordered member should be ADSEP'd - CUT THEIR LOSSES

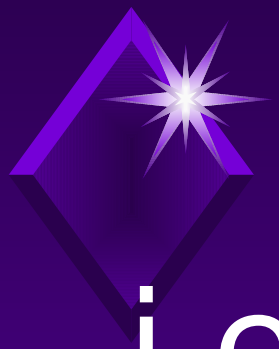
THE MEMBER <u>WILL</u> "UP THE ANTE!!"

Do's and Don'ts

- ***Contracts***:
  - a verbal or written "contract" is NOT the bottom line - this can cause a false sense of security (allays the physician's anxiety without having any effect on the patient's suicidal intent) and several recent litigation cases have proven them invalid
  - much better to document that the pt understands the resources available to him/her and document specific risk elements

Other Psychiatric Emergencies

Anyone at significant risk to harm themselves or someo else can be considered a psychiatric emergency



i.e. - are they suicidal, homicidal, or psychotic?

Keep it simple - first determine the above and then sort out the

Clinical Presentations

- subdued behavior
- agitated behavior
- bizarre behavior
- perfectly normal behavior

How to handle a suicidal, homicidal, or psychotic patient

- **FIRST AND FOREMOST ENSURE SAFETY** (of patient ***and*** you)
- Follow do's/don't already discussed
- Always err on the conservative side (at minimum contact a psychiatrist or psychologist to discuss case before releasing)
- Listen to your primary process: if you are uncomfortable being alone with a patient, **DON'T BE ALONE WITH THEM**

Preventive Measures

- Review your clinic restraint plan - if it doesn’t exist get some help and develop one - it may be as simple as call MPs
- Understand the principles of verbal, chemical, and physical restraint and logistics involved
- Know policy/legal requirements: suicide evals, Tarasoff, Boxer

Tarasoff - duty to warn/protect

- Based on 1974 and 1976 CA rulings - MHPs have a duty to protect third parties from the dangerous acts of their clients
- Requirements vary state-state
  - FL - trend in case law to reject requirements and reasoning in Tarasoff - psychiatrists MAY contact third parties or law enforcement if a threat is made to an identifiable victim, the pt has the capability to carry out such an act and is more likely than not to do so in the near future